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RECOVERY IN TEN: AN INCLUSIVE MODEL OF RECOVERY FOR RISING GENERATIONS

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BY

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Abstract

For decades, the 12-step model has been the *go-to* for substance use treatment. Programs such as Alcoholics Anonymous have given individuals in recovery the space to recover and reclaim their lives. However, research has shown this recovery to be directly influenced by the individual's religion and his or her reliance on a higher power. For those who subscribe to a religion outside of Christianity, or have no religious backing at all, 12-step program can be disadvantageous. The lack of true inclusivity, as well as the verbal degradation of one's self, has turned many away from this method. For those who seek treatment and do not wish to rely on a higher power, as well as those who prefer self-empowerment, there are other options such as SMART Recovery. Unfortunately, alternative methods do not allow for certain components that can be critical to recovery, such as the celebration of milestones. In an attempt to unify the critical components, many deem necessary for recovery from the varying programs, an alternative was created (the 12-Step Alternative). Feedback on this alternative model and the verbiage used within it was gathered effectively leading to the steps being refined and the renaming of the model (Recovery in Ten). This doctoral specialization project aims to provide clinicians with a treatment manual to guide them through the provision of an alternative method for recovery.

Acknowledgements

I would like to take this time to acknowledge those who have helped make this idea of mine become a reality. I want to start with Dr. Michael McClellan, who took the time to sit down with a first-year doctoral student holding a crumpled piece of paper containing the first attempt at an alternative model for recovery. Thank you for everything you put into the foundation of this and working tirelessly side-by-side through the research, rejections, and alterations. Thank you for your consistent encouragement and your constructive criticism. Above all, thank you for being a patient and kind mentor and friend. Thank you to my cohort members, specifically those who were a part of the foundation of this project, those that I consider both my colleagues and chosen family: Craig Brandon Creech and Anna Rose Stanton. Thank you for the countless hours of research, coding, perspective, and support. Thank you to those young adults who provided me with the awareness that a new method to recovery was needed. Lastly, I want to thank my ever-encouraging wife, Casey Camargo, for the perspectives, for listening, and for always being there throughout this entire process- I could not have done it without your support.

Dedication

I would like to dedicate this doctoral specialization project to anyone and everyone who has ever felt they did not have a place to be themselves, to those who wanted to work towards the version of themselves they aspired to be, and to those who were and are the minority. This work is evidence that when there is not a way, we can make one. That with the passing of time, new life can be breathed into old ways and we can make room for generations to come.

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I. Introduction

Purpose

With each emerging generation, we continue to evolve, grow, and learn from previous experiences. This is often witnessed in a variety of aspects such as culture, religion, sexuality, politics, and health care. When these changes happen, adaptations have to be made to successfully continue. A prime example of this is recovery methods for those suffering from addiction. The main treatment approach for recovery remains to be the 12-Step program (Sharma & Branscum, 2010), most notably implemented within Alcoholics Anonymous (AA), which has maintained the same steps since its beginning in 1935 (Alcoholics Anonymous, 2001; Appendix A).

While other options have developed over time (such as the SMART Recovery program; Kelly et al., 2017), none have gained the same notoriety and lack aspects that are of great significance (i.e. milestones to celebrate) as traditional 12-step programs. Thus, the creation of an alternative model that allowed for celebratory milestones while cultivating inclusivity took place. The main objective of this doctoral project is to create a treatment manual that will guide clinicians through the implementation of this alternative model, known as Recovery in Ten (Appendix B). This alternative was designed to allow for inclusivity within a vastly diverse society by building off of a strong foundational tool for recovery.

Statement of Significance

Addiction continues to be a prevalent issue generation after generation (Yaugher et al., 2020). Yaugher et al. (2020) reported that in 2017, the United States had more drug

overdose deaths than fatal automobile accidents. The authors further noted that fatal opioid overdoses (70, 237) had nearly doubled in 2017 from what it was in 2007 (47,600). With substance addiction continuing to be on the rise (Azagba et al., 2021), culturally inclusive treatment options for recovery is an essential component in seeing a reduction in addiction rates take place (Unger et al., 2012).

As previously mentioned, the 12-step program for AA and Narcotics Anonymous (NA) remain to be the "go-to" for addiction treatment and maintenance (Penn et al., 2016). However, for those who do not put their faith in a higher power, as well as those who have no religious backing at all, this model can be seen as a barrier to treatment (Magura, 2007). Furthermore, Broyles et al. (2014) emphasizes that verbiage such as "defect of character" (step 6) and "willpower" (step 3) can be problematic. Thus, a refined alternative that takes into account where previous models fall short and allows for those in need, regardless of religious background, is a critical component to an ever-growing problem.

Distribution and Permissions

Distribution will take place at conferences and, upon expansion, web-based access and continuing education courses. No permissions necessary for the incorporation of Recovery in Ten, as the creator is the writer.

II. Literature Review

Methods of Literature Search

Articles were accessed by utilizing Academic Search Complete and Google Scholar databases through the Eastern Kentucky University Library website. Using these databases, entries within catalogues including, but not limited to PsycINFO and APA PsycARTICLES were utilized. The keywords utilized while searching databases included (but were not limited to) “recovery,” “12-step,” “religion,” “millennial,” “generation Z,” “generation X,” “addiction,” “substance use,” “alternative,” and “alcoholics anonymous.” Print sources included Alcoholics Anonymous (4th ed.; 2001), Substance Abuse: Information for School Counselors, Social Workers, Therapists and Counselors (5th ed.; Fisher & Harrison, 2012) and Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013).

Addiction

Substance misuse has remained a prevalent issue throughout history (Azagba et al., 2021). As previously touched on, deaths due to overdose accounted for over two and half times as many deaths in 2017 than in 2007, equating to nearly 20,000 lives lost each year within a decade (Yaugher et al., 2020). Yaugher et al. (2020) details that 20.3 million people reported experiencing a substance use disorder (SUD) in 2016, over 14 million people reported having an alcohol use disorder, more than 8 million reported an illicit substance use disorder, and over 4 million reported having a marijuana use disorder.

The DSM-5 denotes 10 different drug classes including alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, or anxiolytics (note that

sedatives, hypnotics, and anxiolytics are within the same class), stimulants, tobacco, and other/unknown (APA, 2013). APA (2013) details that a diagnosis of SUD can be applied to 9 out of the 10 classes, caffeine being the only exception. For example, should an individual meet the criteria for a SUD in the form of alcohol, they would be diagnosed with Alcohol Use Disorder (APA, 2013). APA (2013) further includes that an individual can be diagnosed with substance intoxication or withdrawal as well (i.e. Alcohol Intoxication or Alcohol Withdrawal).

Models of Addiction

Mollick and Kober (2020) theorize that models of addiction simplify the complexity addiction (i.e., symptomology, environment, biology, and neurological factors) while maintaining an understanding of the important aspects regarding the disease. Fisher and Harrison (2012) list these models of addiction, which include the moral model, sociocultural models, psychological models, disease model, and biopsychosocial model. The authors describe the moral model as classifying those who use substances as doing so by choice and characterize addiction as a moral deficiency. Furthermore, they explain addiction based on sociocultural models as being heavily influenced by culture, ethnic, religion, and environmental conditions. Psychological models are described as a secondary symptom that results from an underlying psychological disorder. The disease model defines addiction as being a disease likely due to a genetic predisposition, and the biopsychosocial model as having influences from a multitude of interacting variables that vary in significance by the individual (Fisher & Harrison, 2012).

Prochaska and DiClemente (1983) created an integrative model that examined the process of an individual's intentional behavior change. Soberay et al. (2014) identify the transtheoretical model of change and note the importance of identifying the individual clients' current stage when considering readiness for change. Prochaska and DiClemente (1983) describe the stages of change model as precontemplation, contemplation, determination, action, relapse, and maintenance. Soberay et al. (2014) further detail that these stages are not in concrete order and progression can vary drastically based on the individual. Each stage is identified as having its own unique challenges and the individual's current stage of change can directly affect their ability to progress in treatment (Soberay et al., 2014).

Romain et al. (2018) further details what each stage consists of. They detail that the first stage, precontemplation, involves the individual not being ready to progress or not having intent to change. Moving into the second stage, contemplation, the authors describe the individual as getting ready and/or having intent to change in the near future. Stage three, as noted by the authors, entails that the individual is ready and has intent to change and is known as the preparation stage. They continue to describe stage four, action, as the time when the individual initiates the new behavior and the final stage, maintenance, as having the individual sustain the new behavior for more than six months.

Fisher and Harrison (2012) define relapse as the reemergence of substance use following a period of abstinence. The authors note that a significant number of those who receive treatment for a SUD begin using substances again after leaving treatment. They specifically noted that 71% of those with SUD relapse following a period of abstinence.

Fisher and Harrison (2012) express that relapse prevention is crucial and entails assessment of high-risk situations, coping skills, support systems, and lifestyle changes.

Clinician-Ran Versus Peer-Ran

Data regarding success rates and/or preferences for clinician-ran versus peer-ran treatment programs is limited. However, as Penn et al. (2016) note, client perspectives on engaging in treatment, as well as the treatments design and planning, are critical yet not often sought out. They further suggest that two of the most-used modalities for SUD treatment are the 12-step program and cognitive-behavioral therapy. When the authors examined feedback based on programs that had a trained facilitator versus those that were entirely peer-based, they found that facilitators were able to educate others on boundaries, empowerment techniques and terminology, and were noted to be "skillful and helpful." Penn et al. (2016) further reported that clients found peer-ran groups such as the 12-step program to be "dominated" by a single member often times and the quality of meetings were reported to be "inconsistent." Specifically, they found that client-centered treatment was highlighted more effectively with treatment programs that were facilitated by a clinician (Penn et al., 2016).

Major Types of Addiction Recovery

Similar to interventions for Posttraumatic Stress Disorder, Major Depressive Disorder, and Obsessive-Compulsive Disorder, the "one size fits all" method is ineffective, ultimately requiring various intervention options based on the individual's specific requirements. Camargo et al. (2020) identify the four main categories for addiction treatment as: faith-based recovery (Flaherty et al., 2014), secular recovery (Sotskova et al., 2016), natural recovery (Conde et al., 2016), and medication-assisted

recovery (Steiker et al., 2013). Each major category contains various strengths and weaknesses both generally and based on individual needs. Furthermore, there are individual psychotherapeutic approaches that are available as well and are often used in conjunction with one of the four options listed above (Buddie, 2004). Buddie (2004) provides examples including cognitive-behavioral therapy (CBT), alcohol behavioral couple therapy (ABCT), cue exposure (CE), and motivational enhancement therapy (MET). These examples are further detailed below.

Faith-Based Recovery

The incorporation of one's religion into the process of recovery can be invaluable and empowering (Camargo, 2020). Programs such as AA directly incorporate the belief in a higher power into their recovery model (Walters, 2002); allowing for certain individuals' worst times to be combatted with their most empowering support system. Kelly et al. (2011) and Kelly and Yeterian (2012) highlight key benefits of using this model, including the social aspect with emphasis on support, low financial requirements, an increased likelihood of abstinence from substance use, and easy access to short- and long-term recovery support to prevent relapse.

Secular Recovery

Sotskova et al. (2016) describe this method as having a focus on sobriety, secularity, and self-help. The authors provide the example of a program called "LifeRing." This recovery program encourages complete abstinence from all substances, does not incorporate religion or spirituality, and emphasizes self-control (Sotskova et al., 2016). Another, more well-known example, is Self-Management and Recovery Training (SMART; Kelly et al., 2017). The authors note that this program incorporates evidence-

based practices such as motivational interviewing and cognitive behavioral therapy while encouraging interactive discussions on more than just addiction-relevant issues.

Natural Recovery

This method focuses on recovering "naturally" without the use of any interventions, meetings, or medications (Mudry et al., 2019). The authors describe this as the process of overcoming problems without formal help and lists the other names the phenomenon may go by: "spontaneous recovery," "spontaneous remission," and "unassisted recovery." Dawson et al. (2005) further elude that 72.4% of individuals who recovered from alcohol dependence did so without formal intervention.

Medication-Assisted Recovery (MAT)

The use of medication in recovery in often used in conjunction with another intervention. For example, Steiker et al. (2013) describe this method being used alongside counseling and behavioral therapies as a means of providing a "whole patient" approach. The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Behavioral Health Statistics and Quality (2013) advocates for MAT as a means to improve patient survival, increase treatment program retention, decrease illicit opiate use, decrease hepatitis and HIV seroconversion, decrease criminal behaviors, increase employment, and improve birth outcomes for the prenatally addicted (Steiker et al. 2013).

Individual Psychotherapy

Buddie (2004) emphasizes the importance of providing various approaches for the complexity of addiction. In addition to group-based and medication managed treatment options, the author provides clinical approaches that can be taken as well. Buddie (2004) details CBT as a means to teach coping skills for relapse prevention and intake reduction.

ABCT is describe by the author as being a specific type of CBT that directly involves the individual's partner to allow for additional support and skills. Buddie (2004) also includes CE, which has the client determine "drinking cues" and proceed to then be exposed to these cues repeatedly in an attempt to reduce the effect of the trigger. Lastly, the author describes MET, which promotes motivation and a commitment to change.

Systems of Support

Similar to locating feedback regarding clinician-ran versus peer-ran groups, locating data on the importance of various support systems was limited as well. However, various accounts of support between group members within treatment programs has been identified (Kelly & White, 2012; Magura, 2007; Penn et al., 2016). Kelly and White (2012) note a common phrase used within these groups, "We may be sick, but we are not all sick on the same day" (p.83). This eludes that a main driving factor for attending AA is social support (Magura, 2007). Penn et al. (2016) supports this in their findings that both clients and counselors found social support to be one of the most positive aspects of 12-step programs. They found that clients often focused on the social aspects, such as personal interactions before, during, and after meetings, rather than content.

Penn et al. (2016) also touches on the importance of support from the therapeutic relationship. They note that client-centered treatment has a significant focus on mutual respect and involves the counselor or facilitator acting as an encouraging figure who sees the individual as equal. The authors stress the importance of a collaborative approach to provide a supportive and reassuring environment (Penn et al., 2016). Fisher and Harrison (2012) further encourage support systems, explaining that family, friends, and the clinician are crucial for recovery.

Emphasis on Self-Reliance

Walters (2002) reviews the first steps of the Twelve Steps, noting that it requires the individual to "admit" one's powerlessness to the addiction, call on a higher power, and surrender oneself over to this power. The author proceeds to state that this powerlessness can become a hindrance to the healing process because it regards the individual as passive, rather than an active participant in their own recovery. Furthermore, Walters (2002) details that "a robust and complex self-image can serve a protective function in an otherwise vulnerable individual" (p. 56).

Choo and Marszalek (2019) detail the concept of individualism and its emphasis on independence, self-focus, and autonomy. They describe the concept of autonomy specifically, noting that it is often viewed as one of our most prominent psychological needs and a necessity for personal growth. That being said, they also specify that it is imperative to include supportive factors as well, so one does not become isolated. While there is vastly limited literature highlighting the importance of committing oneself to social supports, careers, etc., having these factors as a focus of motivation and perseverance is arguably a necessity for recovery.

Choo and Marszalek (2019) further conceptualize on the prominent components of oneself by highlighting the importance of self-compassion. They note that this entails three intertwined factors: self-kindness, rather than judgement/criticism, common humanity in place of isolation, and mindfulness over rumination. Allowing oneself to acknowledge and grow from their flaws, rather than degrading themselves (Choo & Marszalek (2019).

Impact of Verbiage

The use of language in addiction recovery is a factor that should come with great attention to detail (Robinson, 2017). This may involve a focus on verbiage when incorporating religious aspects (Kelly et al., 2017; Magura, 2007) or the terminology used when referring to the individual in recovery (Broyles et al., 2014; Magura, 2007; Robinson, 2017). Magura (2007) determined that approximately 60% of clients in substance misuse treatment found the religious aspects of the traditional 12-step model for recovery to be an obstacle to participation. Moreover, Kelly et al. (2017) imply that the religious component is not the greatest benefit when implementing the traditional 12-step model. The authors report that the benefit instead comes from the social, cognitive, and affective mechanisms that correspond with the program. Specific to terminology, Broyles et al. (2014) regarded terms such as "abuser" and "junkie" as a means of propagating stigmatized beliefs based on "deficits" in one's "morals, personality, or willpower."

Furthermore, Broyles et al. (2014) point out the use of problematic language use within the traditional 12-step model. These issues include the concept of "willpower" contained in step 3 and the statement "defect of character" contained in step 6 due to the implication that addiction is based on one's willpower, not a genetic disposition (Broyles et al., 2014). Camargo et al. (2020) advocate that due to these factors (i.e. stigmatized language use and religious implications), the religious aspects of faith-based recovery such as the traditional 12-step model can actually "serve as an unnecessary barrier to treatment within the addiction community" (p. 4)."

Impact of Milestones

The act of creating small goals when you are trying to accomplish one large goal can not only make the process more manageable, but it can also give someone moments to celebrate their triumph upon each completion (Wiebe et al., 2018). The authors note that both the structure and multi-step process have been proven to be helpful throughout recovery. These reminders of progress can instill hope and encouragement, provide structure, and reinforce abstinence from substance use (Camargo et al., 2020; Kelly et al., 2011; Wiebe et al., 2018; Witbrodt et al., 2012).

Emerging Generations and Religion

As previously stated, throughout each generation, we witness the progression of society as we know it. Gentile et al. (2014) suggests that generational cohorts represent their own dimension of culture, containing distinct cultural values, beliefs, and attitudes. Two of the youngest generations, Millennials and Generation Z, collectively make up nearly 70% of the U.S. population (Frey, 2018; Heller, 2015). Frey (2018) defines the millennial generation as individuals born between 1980 and 1994, making up approximately 44% of the U.S. population. Heller (2015) reports that Generation Z represents individuals born between 1995 and 2010, comprising of 25% of the U.S. population.

A plethora of studies ranging from the early 2000s to present day imply that religious practice, as well as general belief systems, have become less prioritized for both Generation Z-ers and Millennials (Barna Group, 2019b; Hout & Fischer, 2002; Pew Research Center, 2014). The Barna Group (2019b) noted a downward trend of religiosity, detailing that Millennials report less religious focus than the prior generation (Generation

X) and Generation Z-ers reported a further decrease of religiosity than Millennials. Further studies revealed that 22% of Millennials identified as religiously unaffiliated whereas 13% of Generation Z-ers identified as Atheists when compared to 6% of the general U.S. population and 14% identified as religiously unaffiliated (Barna Group, 2019a; Pew Research Center, 2014). It is worth nothing that data regarding earlier generations such as Baby Boomers and Generation X is vastly limited.

Moving Forward

Upon examining the current literature regarding addiction and the plethora of factors that recovery from substance misuse entails (i.e. recovery method, support systems, self-reliance, etc.), it is clear that a foundation has been set, but there is still much to expand upon. Specifically, emerging generations such as Millennials and Generation Z continue to represent a downward trend regarding religiosity (Barna Group, 2019a; Pew Research Center, 2014). Therefore, it is critical to provide new methods of recovery for new generations. Below, a program providing foundational incorporations (i.e. milestones) in conjunction with emerging trends (i.e. decreases in religiosity) is proposed.

III. Original Contributions to Practice

Proposed Program

The purpose of this project is to develop a treatment manual for Recovery in Ten. This manual would be utilized in an environment that is clinician-led within a group setting. It is believed that this program would provide an environment for individuals from various ideological belief systems. Specifically, this could allow for those with differing religions and spirituality to come together and recover in an environment that encourages individuality and introspection of self.

A major complaint espoused by individuals who reject the traditional 12-step model is the verbiage used (Robinson, 2017). In an attempt to rectify this issue, Alcoholics Anonymous (2001) revised their literature to include *We Agnostics, Chapter 4*. However, the 12-step model remained unchanged from its origin in 1935. Due to this, the word "God" continues to be directly referenced in five of the twelve steps (Alcoholics Anonymous, 2001). This program aims to alleviate this by removing both references of a higher power, as well as potentially harmful language. However, Recovery in Ten does maintain the multi-step model to allow for celebratory milestones and encourage resilience.

Refining the Alternative Model

The idea to create an alternative model that would examine the traditional 12-step model and incorporate its praises and counter its shortcomings began in 2016. Originally, the alternative model was 12 steps, mirroring the traditional 12-step program. Due to this, the model was simply referred to as the "12-Step Alternative" until the decision to change it to "Recovery in Twelve" over time. Following Camargo et al.'s (2020) study, the

decision was made to refine this model down to 10 steps. This decision was made in an attempt to consolidate steps that were somewhat redundant while maintaining milestones. Recovery in Ten consolidated and condensed steps and removed redundancy in order to make the program more manageable.

Recovery in Ten

Below, the finalized steps of Recovery in Ten are detailed. Within them, the rationale, potential experience of the involved individual, and examples are provided. It should be noted that every person's experience will differ, and these are simply hypothetical possibilities.

Step One: We acknowledge our loss of control to the addiction.

Clinicians should maintain heightened awareness during this step for clients' readiness for change using the stages of change model. Below are the main goals to focus on during this step:

- Internal and external admission of a need for assistance in regaining control of the addiction and admittance that it has taken control of multiple aspects of the individuals lives.
- Gauging awareness that from the moment individuals with addiction wake up to the moment they fall asleep, the individuals' thoughts revolve around their addiction. Where it is, how to get it, who I can get it from, how it will make them feel, reset, repeat.
- Determining if the individual feels that nothing comes before the addiction, no person, place, or thing, the individual included.

Step Two: We came to the realization that we need help overcoming the addiction and recognized that we have a willing support system to assist us.

Clinicians are encouraged to gauge awareness of readiness to receive support as well as the amount of support the individual may have. Below are the goals for this step:

- Readiness to admit the they need help and that they cannot do it alone.
- Identifying the support system the individual has around them to help manage and overcome the addiction.
- Prepare to begin taking steps to put themselves, their future, career, education, etc., and their loved ones before the addiction.

Note that some people that may be in this support system could be family, supportive friendships, mentors, role models, and mental health professionals. It is important to recognize in this step which relationships are healthy ones versus relationships that will continue to pull the individual back towards addiction. The process of considering who to pull in and who to let go begins.

Step Three: We became open, willing, and ready for change.

Accepting help and being open to change are very difficult things for most, this is no different for those in recovery from addiction. Here, clinicians should continue to monitor what stage of change the individual is in and gauge for readiness. Below are the goals for this step:

- The expectation to be held accountable by their support system as well as themselves.
- Eliciting feedback about what aspects of their lives need to change in order to create and maintain a sober lifestyle.

- Coming into this step knowing that in order to be successful in recovery, change must take place. Changes in themselves, changes in their habits, changes in the community they surround themselves with.
- Acknowledging that some of the hardest changes they might have to make is choosing to leave behind some of their closest friends. Realization that they may not be the healthy influences the individual currently requires.
- Awareness of the fear, pain, and shame that they may encounter throughout these changes begin.
- Acknowledgement of the necessity of this process and willingness to allow room for compassion and gentleness.
- A commitment to recovery and openness to a new and sober lifestyle.

Step Four: We gathered the courage and the skills to confidently regain control over the addiction.

Clinicians are encouraged to show continued awareness for readiness towards the next step. Furthermore, skill building begins taking place and coping mechanisms/grounding techniques are incorporated. In this step, clinicians, mentors, peers, and advocates in the group will likely be the individual's biggest allies. Below are the goals for this step:

- While using the support and advice that has been established, begin assessing levels of confidence to overpower this addiction.
- Learning and practicing coping mechanisms when placed in situations that typically would lead to reliance on addiction.

- Seeking guidance from mentors who have gone through recovery in the past to gain potential solutions and ways to maneuver in this envisioned version of themselves that we are creating.
- Collaboratively as client and clinician, identify and challenge underlying issues that, in the past, have led the individual further down the path of addiction.
- Implementing these skills to recognize and redirect oneself from falling back into previous patterns.
- Being cautious of avoidance and rumination.
- Be mindful of the small and large accomplishments along the way.

Step Five: We took the time for honest, unbiased, self-reflection; letting go of excuses.

This step involves having the clinician encourage the client to engage in self-reflection while gently challenging negative patterns of thinking, cognitive distortions, and core beliefs. Reflective listening and Socratic questioning are recommended when deemed appropriate. Below are the goals for this step:

- Looking within oneself, review the decisions, hardships, and moments that led oneself down this path to addiction. This understanding may aid the individual in redirection rather than reverting back to previous methods of coping.
- With self-reflection, look back through every stage of life and conceptualize moving forward.
- Prior to the addiction and during the battle with substance use, reflect on the following questions: *What did we like about ourselves? Dislike? What hardships did we face? What, if anything, did I feel I was lacking? Did I have*

others to turn to? Were there things we wanted to change? How do we see ourselves emerging from addiction? Did we see ourselves overcoming it? What led to you seek services/support?

Step Six: We applied the 5 W's (who, what, when, where, and why) to our past and current misconduct while taking ownership of them.

Moving on from Step 5, have the client take the answers to those questions and dive deeper into some of the misconduct deemed significant. Continued reflection and gentle challenging are encouraged. Role-playing may be incorporated during this step. Below are the goals for this step:

- Acceptance of the involvement in misconduct.
- Identify how the situation may take place if it were to repeat itself now that awareness has been regained.
- Merge towards acceptance as to why our past decisions were made and how to move forward. *What changes can I make to prevent the past from repeating itself?*
- Identifying and addressing past trauma, unmet needs, residual feelings of great significance, etc.
- Awareness and acknowledgement of a new future begins.

Step Seven: We made a list detailing our wrongdoings of others and shared them with our support group while remaining open to feedback from our peers.

Clinicians should remain aware of potential defensiveness and maintain awareness of the environment (i.e. posture, tone of voice, etc.). Furthermore, while

facilitating discussions, clinicians should be vigilant about validation and verbal interactions between peers. Below are the goals for this step:

- Reflect on how decisions have affected loved ones.
- Putting the acts of misconduct into something tangible, a physical document, and sharing the document with peers when ready.
- Remaining open to feedback, understanding that there may be perspectives not previously considered.
- Avoiding defensiveness about this feedback so long as it is appropriate.
- Listening to hear, rather than listening to respond.
- Identifying past and present patterns/habits.

Step Eight: After careful preparation, we contact those we have wronged to make amends unless doing so brought more harm than good.

During this step, the clinician is advised to provide support to the client making amends but should strongly advise the client against attempting to make amends to those that may cause harm or present a risk. The clinician should directly state that the decision to make amends is the client's choice. Clinicians should maintain awareness and inquire for potential hostility towards those the client wishes to make amends with. Below are the goals for this step:

- Reaching out to those the individual has wronged, acknowledging the error and clearly stating the attempt at correction. Avoidance similar errors in the future.

- Understanding that making contact with some of those have been wronged could cause more harm than good for either party. Acknowledgement that the decision to make amends and make contact is the individual's choice alone.
- Continue to improve on oneself and their relationships, to make amends for oneself and those they care for. For example, acknowledgment of not being there for those who have always been there for the individual or rectifying the damaged/harm caused to others while under the influence.

Step Nine: We created a one-, five-, and ten-year plan that we reviewed and shared with our peers often.

The clinician is encouraged to facilitate this activity and provide examples. Reflective listening and Socratic questioning are recommended when deemed appropriate. Maintenance of environment and awareness of cues should be a priority. Below are the goals for this step:

- Set one's purpose and goals to work towards to encourage us to keep pushing forward.
- Short-term and long-term goals give the individual the opportunity to celebrate the small accomplishments along the way but also keep one's eyes forward on bigger things.
- Examples of one-year plans could be to achieve one year of sobriety, maintaining a stable job, or finding safe and reliable housing.
- Examples of a five-year plan could be to obtain a desired degree, certification, or promotion.

- Ten-year plan could include starting a family, a career, or buying a home you have envisioned yourself living in; accomplishments that will take years to develop.
- These plans should have goals or achievements that are personal and meaningful for the individual specifically. No one plan is "better" or "more important" than another.
- Sharing this plan with others adds to accountability and also adds to the celebration once goals are met.
- Peers may also be able to aid in the accomplishment of each of these goals.

Step Ten: We will always be willing to share these steps with others in need; inviting them to continue attending group meetings with us and engage in self-reflection and progress.

The clinician is encouraged to invite members that are currently at this step to take a more involved role, providing opportunities to share their stories, guidance, and methods. Clinicians should continue to facilitate productive discussions, be aware of setbacks, and encourage an outlook on future directions. Below are the goals for this step:

- Willingness to provide insight and encouragement.
- Gentleness and understanding during the times where the individual is unable to mentor or be a positive role model.
- Provide validation and support to those in need.
- Becoming a leader/mentor to an individual currently in earlier steps.

Implementation

The main idea behind this treatment manual is to provide an inclusive option for anyone in need of assistance with addiction. In order to locate potential members, I would aim to distribute the option to enter this program to college campuses, specifically college counseling centers, recovery centers, as well as non-denominational and denominational religious affiliations. Admission into the program would be as open as possible with the mindset being to develop an all-inclusive recovery program. Requirements would include prior substance use or substance-related issue, readiness to attempt recovery (i.e., maintaining sobriety), must be seeking recovery voluntarily, and portrays the ability to regulate emotions in a situation appropriate manner. To determine if an individual would be well suited for this program, a screening would take place that included a brief intake, determination of the individual's current stage of change following Romain et al.'s (2018) guidance, and administration of the Minnesota Multiphasic Personality Inventory-3 (MMPI-3; Ben-Porath & Tellegen, 2020). Incorporating the MMPI-3 is recommended due to its ability to capture a broad array of internalizing, externalizing, and thought-disordered psychopathology. Specifically, the measure could assist in conceptualizing the individuals origin of substance misuse and potentially identify co-occurring issues. Furthermore, the MMPI-3 (Ben-Porath & Tellegen, 2020) could be used to determine goodness-of-fit and readiness for group interaction and recovery by eluding to potential therapy-inferring behaviors (i.e. impulsivity, anger proneness, cynicism, antisocial behavior, and disconstraint).

When implementing this treatment manual, clinicians should plan to check-in for 15 minutes, spend 30 minutes focusing on the current step (i.e., detailing what the step is,

expectations and goals for this step, considerations, etc.), 30 minutes for group processing regarding the step, and 15-minute check-out. The structure of this intervention would revolve around weekly group meetings. The meetings would focus on open group discussions regarding personal struggles, experiences, and growth as it relates to their journey with addiction. These discussions would aim to progress individuals through the Recovery in Ten program at their own pace and would offer support throughout their process. Group meetings would be clinician-ran in order provide professional insight, coping skills, mindfulness techniques, and deescalate potential crises. Furthermore, psychoeducation, exploration of core beliefs, identification of cognitive distortions, exploration of traumatic history and potential triggers, and communication skills will be incorporated.

Measures

Participants will be asked to complete the following screeners to allow clinicians to set a baseline for participants and measure progress:

The Drug Abuse Screening Test (Skinner, 2001; Appendix C) is a 20-item screening measure of problematic drug use. Participants respond yes (1 point) or no (0 points) to each item with the exception of items 4 and 5 which were reverse scored based on scoring guidelines offered in the literature. Total scores are calculated by summing the points for each item and the total score ranges from 0–20 points with higher scores representing more problematic drug use.

The Michigan Alcoholism Screening Test (Selzer, 1971; Appendix D) is a 24–26 item screening measure for alcoholism. Participants respond yes or no to each of the 24 items. If participants respond yes to either item 23 or 24, they are asked the follow-up

item of “how many times?” to get more information. Scoring values for each item ranged from 1 to 5 for the 24 items with potentially higher scores on items 23 and 24 depending upon the number a participant provided for the “how many times?” follow-up question and then multiplying the item score for those items by the number of times the participant noted in the “how many times?” follow-up question. Final scoring is determined by summing the total number of points for each item with higher scores representing a higher likelihood of problematic alcohol use.

The following measure will be provided once per participant for research purposes:

Belief Into Action Scale. The BIAS (Hafizi et al., 2016; Appendix E) is a 10-item measure of organizational and non-organizational religious activities and level of personal commitment to one’s faith. Participants rate all items 1 or 10. Total scores are calculated by summing the points for each item with overall scores that range from 10 to 100 points. Higher scores suggest higher participation in religious activities and higher level of personal commitment to faith.

Program Evaluation

In order to determine efficacy of this program, participants will be asked to answer standard questions in the form of a short survey (Appendix F). This will be a voluntary and completely anonymous survey used for the purpose of both efficacy and future research on alternative methods for recovery. The questions examine components such as demographics, reasoning for selecting this program, etc. Clinician’s working with the individual filling out this measure will have no access to their answers and are not

permitted to inquire about how they respond. Furthermore, posttest evaluations on group and content satisfaction, success rates, and inclusivity will be conducted.

Future Directions

Upon completion of the manual, clinician's will be able to implement this treatment program. In compliance with insurance requirements, each group will contain no more than 12 members and one clinician. A website would need to be developed to make access to clinicians easier regardless of physical location. It is imperative that each group using Recovery in Ten leads the program with the same structure. Furthermore, expanding to a wider variety of treatment facilities and populations is also a major goal. For example, outreach to departments such as Veterans Affairs (VA) and court intervention referrals. As previously state, inclusivity is key.

The world is ever changing, and this program will need to be open to that growth and willing to accommodate to change. The object of Recovery in Ten is to provide a recovery option that would benefit people from all aspects of life and to navigate around barriers to recovery. To do this, we need to build from the foundation that has been created; incorporate research and science, alongside personal experiences and individual needs, to create a new way to recover for new generations.

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APPENDIX

Appendix A: Original 12 Steps

Step Number	Description
Step One	We admitted we were powerless over “alcohol”- that our lives had become unmanageable.
Step Two	Came to believe that a Power greater than ourselves could restore us to sanity.
Step Three	Made a decision to turn our will and our lives over to the care of God as we understood Him.
Step Four	Made a searching and fearless moral inventory of ourselves.
Step Five	Admitted to God, ourselves, and to another human being the exact nature of our wrongs.
Step Six	Were entirely ready to have God remove all these defects of character.
Step Seven	Humbly asked Him to remove our shortcomings.
Step Eight	Made a list of all persons harmed, and became willing to make amends to them all.
Step Nine	Made direct amends to such people wherever possible, except when to do so would injure them or others.
Step Ten	Continue to take personal inventory, and when we were wrong, promptly admitted it.
Step Eleven	Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
Step Twelve	Having had a spiritual awakening as the result of these steps, we tried to carry this message to “alcoholics” and to practice these principles in all our affairs.

(Alcoholics Anonymous, 2001)

Appendix B: Recovery in Ten

Step Number	Description
Step One	We acknowledge our loss of control to the addiction.
Step Two	We came to the realization that we need help overcoming the addiction and recognized that we have a willing support system to assist us.
Step Three	We became open, willing, and ready for change.
Step Four	We gathered the courage and the skills to confidently regain control over the addiction.
Step Five	We took the time for honest, unbiased, self-reflection; Letting go of excuses.
Step Six	We applied the 5 W's (who, what, when, where, and why) to our past and current misconduct while taking ownership of them.
Step Seven	We made a list detailing our wrongdoings of others and shared them with our support group while remaining open to feedback from our peers.
Step Eight	After careful preparation, we contact those we have wronged to make amends unless doing so brought more harm than good.
Step Nine	We created a one, five, and ten-year plan that we reviewed and shared with our peers often.
Step Ten	We will always be willing to share these steps with others in need; inviting them to continue attending group meetings with us and engage in self-reflection and progress.

Appendix C: Drug Abuse Screening Test (DAST)

These questions refer to the past 12 months.

	Circle your response
1. Have you used drugs other than those required for medical reasons?	Yes No
2. Have you abused prescription drugs?	Yes No
3. Do you abuse more than one drug at a time?	Yes No
4. Can you get through the week without using drugs?	Yes No
5. Are you always able to stop using drugs when you want to?	Yes No
6. Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes No
7. Do you ever feel bad or guilty about your drug use?	Yes No
8. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes No
9. Has drug abuse created problems between you and your spouse or your parents?	Yes No
10. Have you lost friends because of your use of drugs?	Yes No
11. Have you neglected your family because of your use of drugs?	Yes No
12. Have you been in trouble at work because of drug abuse?	Yes No
13. Have you lost a job because of drug abuse?	Yes No
14. Have you gotten into fights when under the influence of drugs?	Yes No
15. Have you engaged in illegal activities in order to obtain drugs?	Yes No
16. Have you been arrested for possession of illegal drugs?	Yes No
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes No
18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes No
19. Have you gone to anyone for help for a drug problem?	Yes No
20. Have you been involved in a treatment program specifically related to drug use?	Yes No

(Skinner, 2001)

Appendix D: Michigan Alcoholism Screening Test (MAST)

Michigan Alcohol Screening Test (MAST) was developed in 1971, and is one of the oldest and most accurate alcohol screening tests available, effective in identifying dependent drinkers with up to 98 percent accuracy.

Questions on the MAST test relate to the patient's self-appraisal of social, vocational, and family problems frequently associated with heavy drinking. The test was developed to screen for alcohol problems in the general population. The following is the 22-question, self-administered MAST.

The MAST Test

The MAST Test is a simple, self-scoring test that helps assess if you have a drinking problem. Answer yes or no to the following questions:

1. Do you feel you are a normal drinker? ("normal" is defined as drinking as much or less than most other people)
___ Yes ___ No
2. Have you ever awakened the morning after drinking the night before and found that you could not remember a part of the evening?
___ Yes ___ No
3. Does any near relative or close friend ever worry or complain about your drinking?
___ Yes ___ No
4. Can you stop drinking without difficulty after one or two drinks?
___ Yes ___ No
5. Do you ever feel guilty about your drinking?
___ Yes ___ No
6. Have you ever attended a meeting of Alcoholics Anonymous (AA)?
___ Yes ___ No
7. Have you ever gotten into physical fights when drinking?
___ Yes ___ No
8. Has drinking ever created problems between you and a near relative or close friend?
___ Yes ___ No
9. Has any family member or close friend gone to anyone for help about your drinking?
___ Yes ___ No
10. Have you ever lost friends because of your drinking?
___ Yes ___ No
11. Have you ever gotten into trouble at work because of drinking?
___ Yes ___ No
12. Have you ever lost a job because of drinking?
___ Yes ___ No
13. Have you ever neglected your obligations, family, or work for two or more days in a row because you were drinking?
___ Yes ___ No
14. Do you drink before noon fairly often?
___ Yes ___ No
15. Have you ever been told you have liver trouble, such as cirrhosis?
___ Yes ___ No

(Selzer, 1971)

16. After heavy drinking, have you ever had delirium tremens (DTs)[2], severe shaking, visual or auditory (hearing) hallucinations?
___ Yes ___ No
17. Have you ever gone to anyone for help about your drinking?
___ Yes ___ No
18. Have you ever been hospitalized because of drinking?
___ Yes ___ No
19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward?
___ Yes ___ No
20. Have you ever gone to any doctor, social worker, clergyman, or mental health clinic for help with any emotional problem in which drinking was part of the problem?
___ Yes ___ No
21. Have you been arrested more than once for driving under the influence of alcohol?
___ Yes ___ No
22. Have you ever been arrested, or detained by an official for a few hours, because of other behavior while drinking?
___ Yes ___ No

Scoring the MAST Test

Score **one point** if you answered "no" to the following questions: 1 or 4. Score **one point** if you answered "yes" to the following questions: 2, 3, 5 through 22. A total score of six or more indicates hazardous drinking or alcohol dependence and further evaluation by a healthcare professional is recommended.

*Sources

National Council on Alcoholism and Drug Dependence of the San Fernado Valley. Michigan Alcohol Screening Test (MAST)[3]. Retrieved July 2007. Alcohol Concern. Primary Care Alcohol Information Service (PDF). Retrieved 2009.

(Selzer, 1971)

Appendix E: Belief Into Action Scale (BIAS)

Belief into Action Scale

Circle a single number for each question below:

1. Please circle the highest priority in your life now? (most valued, prized)

1. My health and independence
2. My family
3. My friendships
4. Job, career or business
5. My education
6. Financial security
7. Relationship with God
8. Ability to travel & see the world
9. Listening to music and partying
10. Freedom to live as I choose

2. How often do you attend religious services? (circle a number below)

Never	Rarely	Couple times/yr	Every few mos	About once/mo	Several times/mo	About every wk	Every week	More than once/wk	Daily
1	2	3	4	5	6	7	8	9	10

3. Other than religious services, how often do you get together with others for religious reasons (prayer, religious discussions, volunteer work, etc.)?

Never	Rarely	Couple times/yr	Every few mos	About once/mo	Several times/mo	About every wk	Every week	More than once/wk	Daily
1	2	3	4	5	6	7	8	9	10

4. To what extent (on a 1 to 10 scale) have you decided to place your life under God's direction?

Not at all (really haven't thought about it)				To a moderate degree					Completely, totally
1	2	3	4	5	6	7	8	9	10

(Hafizi et al., 2016)

5. What percentage of your gross annual income do you give to your religious institution or to other religious causes each year?

0%	Less than 1%	1%-2%	3%-4%	5%-6%	7%-8%	9%-10%	11%-12%	13%-14%	15% or more
1	2	3	4	5	6	7	8	9	10

6. On average, how much time each <u>day</u> (in 24 hrs) do you spend listening to religious music or radio, or watching religious TV?

0 (never)	1-5 min	6-10 min	11-20 min	21-30 min	31-60 min	More than 1 hr, less than 2 hr	More than 2 hr, less than 3 hr	3-4 hrs	5 hrs or more
1	2	3	4	5	6	7	8	9	10

7. On average, how much time each <u>day</u> do you spend reading religious scriptures, books, or other religious literature?

0 (never)	1-5 min	6-10 min	11-20 min	21-30 min	31-60 min	More than 1 hr, less than 2 hr	More than 2 hr, less than 3 hr	3-4 hrs	5 hrs or more
1	2	3	4	5	6	7	8	9	10

8. On average, how much time each <u>day</u> do you spend in private prayer or meditation?

0 (never)	1-5 min	6-10 min	11-20 min	21-30 min	31-60 min	More than 1 hr, less than 2 hr	More than 2 hr, less than 3 hr	3-4 hrs	5 hrs or more
1	2	3	4	5	6	7	8	9	10

9. On average, how much time each <u>day</u> do you spend as a volunteer in your religious community or to help others for religious reasons?

0 (never)	1-5 min	6-10 min	11-20 min	21-30 min	31-60 min	More than 1 hr, less than 2 hr	More than 2 hr, less than 3 hr	3-4 hrs	5 hrs or more
1	2	3	4	5	6	7	8	9	10

10. To what extent (on a 1 to 10 scale) have you decided to conform your life to the teachings of your religious faith?

Not at all (really haven't thought about it)				To a moderate degree					Completely, totally
1	2	3	4	5	6	7	8	9	10

(Hafizi et al., 2016)

Appendix F: Demographic Survey

RECOVERY IN TEN

What generation do you best fit in?

☐ Boomers ☐ Millennials

☐ Generation X ☐ Generation Z

What substance are you seeking treatment for?

☐ Alcohol ☐ Opioids

☐ Amphetamines ☐ Cocaine

☐ Methamphetamine ☐ Other

What religious affiliation do you best fit?

☐ Christianity ☐ Islam

☐ Hinduism ☐ Unaffiliated

☐ Buddhism ☐ Other

Do you currently practice the above religion?

☐ Yes | ☐ No

What is your Belief Into Action Scale score?

What is your sexual orientation?

☐ Heterosexual ☐ Bisexual

☐ Gay/ Lesbian ☐ Other

☐ Prefer Not to Answer

What is your Political Affiliation?

☐ Republican ☐ Democrat

☐ Independent ☐ Prefer Not to Answer

What is your Race/Ethnicity?

☐ Caucasian ☐ African American

☐ Hispanic ☐ Prefer Not to Answer

What gender do you identify with?

☐ Male ☐ Female

☐ Other ☐ Non-binary

How long have you been in Recovery in Ten?

What step are you currently working on?

Is this the first time you sought treatment for substance use?

☐ Yes | ☐ No

If not, How many previous times?

Have you struggled to achieve previous steps?

☐ Yes | ☐ No

If yes, Which one(s) and Why?

What drew you to Recovery in Ten?

Please share any additional comments or suggestions.